GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 20, 2025

Laura Hatfield-Smith
ResCare Premier, Inc.
Suite 1A
6185 Tittabawassee
Saginaw, MI 48603

RE: License #: AS730307068
Investigation #: 2025A0576033
ResCare Premier Vienna

Dear Laura Hatfield-Smith:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,

Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 240-2478

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS730307068
Investigation #:	2025A0576033
Complaint Receipt Date:	04/14/2025
Investigation Initiation Date:	04/15/2025
Report Due Date:	06/13/2025
Licensee Name:	ResCare Premier, Inc.
Licensee Address:	9901 Linn Station Road, Louisville, KY 40223
Licensee Telephone #:	(989) 791-7174
Administrator:	Laura Hatfield-Smith
Licensee Designee:	Laura Hatfield-Smith
Name of Facility:	ResCare Premier Vienna
Facility Address:	828 E. Broad St., Chesaning, MI 48616
Facility Telephone #:	(989) 845-1781
Original Issuance Date:	04/22/2010
License Status:	REGULAR
Effective Date:	11/14/2024
Expiration Date:	11/13/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Manager, Courtnee Baroski-Carsten crushed clonazepam tablets and mixed them with water. The mixture was added to Resident A's liquid bottle of clonazepam.	Yes

III. METHODOLOGY

04/14/2025	Special Investigation Intake 2025A0576033
04/15/2025	Special Investigation Initiated - Letter Sent email to Jody Marsh, Livingston County Community Mental Health (CMH)
04/15/2025	APS Referral
04/15/2025	Contact - Document Received Received email from Jody Marsh
05/05/2025	Inspection Completed On-site Interviewed Staff, Brianna Williams and Residential Coordinator, Davina McCaskey
05/09/2025	Contact - Document Received Reviewed Incident Report (IR)
05/13/2025	Contact - Telephone call made Interviewed Staff, Andromeda Warren
05/13/2025	Contact - Telephone call made Left message for Courtnee-Baroski-Carsten to return call
05/15/2025	Contact - Telephone call received Interviewed Cortnee Baroski-Carsten
05/16/2025	Exit Conference

ALLEGATION:

Manager, Courtnee Baroski-Carsten crushed clonazepam tablets and mixed it with water. The mixture was added to Resident A's liquid bottle of clonazepam.

INVESTIGATION:

On April 15, 2025, I sent an email to Judy Marsh, Livingston County Office of Recipient Rights (ORR) Investigator regarding any updates she can provide. Investigator Marsh reported she has spoken to some staff regarding the allegations and not the manager.

On May 5, 2025, I conducted an unannounced on-site inspection at ResCare Premier Vienna and interviewed Staff Brianna Williams. Staff Williams reported that the allegations are true. Staff Williams reported she read a text message where the Home Manager, Courtnee Baroski-Carsten admitted to crushing up a medication and putting it in water. The water and medication were then put in Resident A's medication bottle. Home Manager Baroski-Carsten did this because she was worried Resident A would run out of the medication. Resident A was administered the medication that was tampered with, and she was taken to the hospital to be examined. According to Staff Williams, Home Manager Baroski-Carsten has been fired from the facility.

On May 5, 2025, I reviewed resident medication and the medication records. There were no concerns noted. I viewed Resident A who was lying in her bed watching television. Resident A appeared content and did not appear to be under any duress. Resident A is nonverbal and could not be interviewed. Resident A is not mobile and requires peg tube feeding. Resident A's medications are all liquid and are provided to her via peg tube.

On May 5, 2025, I interviewed Residential Coordinator, Davina McCaskey. Coordinator McCaskey reported that she received a call on April 11, 2025, from Staff, Andromeda Warren who told her that Resident A's medication was low. Home Manager Courtnee Baroski-Carsten admitted to crushing up pills and mixing them with water and put the water/pills mixture in Resident A's medication bottle. Coordinator McCaskey reported that all Resident A's medications are mail order because she requires a compound pharmacy, and all her medications are liquid. Coordinator McCaskey reported Resident A was terminated from employment.

On May 5, 2025, I viewed a text message that Residential Coordinator McCaskey reported was authored by Home Manager Courtnee Baroski-Carsten and sent to Staff Andromeda Warren. The text message stated "I took pill Clonazepam she had previously and mixed it into the bottle…It wasn't that liquidy when I did it. So, I won't be doing that again. I just didn't want her to go without it."

On May 9, 2025, I reviewed an AFC Licensing Division Accident / Incident Report (IR) dated for April 14, 2025, and authored by Andromeda Warren. The IR documented that on April 11, 2025, Resident A was taken to the hospital "to be medically cleared." Labs,

urine, culture, and EKG were completed and all came back normal. The IR documented that the “staff involved in creating mixed medications was discharged from employment.”

On May 13, 2025, I interviewed Staff, Andromeda Warren regarding the allegations. Staff Warren reported that the Home Manager, Courtnee Baroski-Carsten texted her and told her that she crushed up Clonazepam pills and put them in Resident A medication bottle of liquid Clonazepam as she did not want Resident A to run out of the medication. Staff Warren reported that on April 9, 2025, she noticed Resident A’s medication “looked weird” and the color and consistency “was off”. Resident A was given the medication that was tampered with for at least 2 doses.

On May 13, 2025, I left Courtnee Baroski-Carsten a message to return my call. On May 15, 2025, Manager Baroski-Carsten returned my call, and she was interviewed regarding the allegations. Manager Baroski-Carsten reported she has been cited by recipient rights and has been fired from her job. Manager Baroski-Carsten reported she added water to Resident A’s liquid Clonazepam because she was worried Resident A would run out of the medication. Manager Baroski-Carsten denied crushing any pills and putting them in Resident A’s medication bottle along with water. Manager Baroski-Carsten stated she “shouldn’t have done it" and thought “it would be okay.” Manager Baroski-Carsten denied anyone told her to add water to Resident A’s medication. Manager Baroski-Carsten stated she realizes now that she could have hurt Resident A.

On May 16, 2025, I conducted an exit conference with Licensee Designee, Laura Smith. I advised Licensee Designee Smith I would be citing a rule violation and requesting a corrective action plan. I advised Licensee Designee Smith that this incident should be discussed with all staff if not already done. Licensee Designee Smith advised that Manager Baroski-Carsten was cited by ORR for neglect.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.**

ANALYSIS:	It was alleged that Manager Courtnee Baroski-Carsten crushed up Clonazepam pills and added them to water. The mixture was then added to Resident A's prescription bottle of liquid Clonazepam. Upon conclusion of investigative interviews, there is a preponderance of evidence to conclude a rule violation. Staff including Manager Baroski-Carsten were interviewed and confirmed the allegations were true. Manager Baroski-Carsten denied crushing up pills, however she did admit to adding water to Resident A's medication bottle. Resident A was administered the medication that was modified and was taken to the hospital to be medically cleared. Manager Baroski-Carsten has since been terminated from employment. There is a preponderance of evidence to conclude staff modified Resident A's medication without instructions from a physician or pharmacist.
CONCLUSION:	**VIOLATION ESTABLISHED**

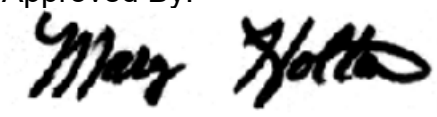
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, no change in the license status is recommended.

5/20/2025

Christina Garza Date
Licensing Consultant

Approved By:



5/20/2025

Mary E. Holton Date
Area Manager